



CBIZ Payroll

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April 13, 2010

Dear Client,

There is a great deal of discussion and debate regarding the potential impact of the health care reform bill on employers and employees. Our job, at CBIZ, is not to speculate, but to help you prepare for what we definitively know is ahead – starting with changes that occur in 2010 and going forward. CBIZ is uniquely positioned to provide fully integrated analysis and advice based upon the multi-disciplinary nature of our company – with major divisions in benefits & insurance, tax and financial services, and payroll.

What follows is a brief summary of the issues that should be foremost in mind for you and your employees as we move toward the fall renewal period. Please review and contact us if you have any immediate questions, as well as to begin the process of adapting to this new legislation.

Summary of key tenets of the bill:

- **Health Cafeteria.**

- **Over-the-counter drug expenses.** Starting January 1, 2011, OTC drugs and medications cannot be reimbursed from an FSA, HSA, MSA or a Health Reimbursement Arrangement (HRA) unless they are accompanied by a doctor's prescription.
However, all is not lost. This new ruling does not exclude all OTC expenses. Example: Items like aspirin and cough syrup would be excluded, unless *prescribed* by a physician. Items such as blood glucose monitors or diabetic test strips can still be purchased on a pre-tax basis without a physician's prescription.
Participants that utilize a healthcare debit card will no longer be able to use their card at the drug store or pharmacy for over the counter (OTC) drugs and medications. If the participant obtains a physician's prescription for these items, they could then submit a claim to their administrator accompanied by a physician's prescription.
- **Health FSA Contribution Limit.** A contribution limit will apply to health FSA, and LFSA starting January 1, 2013. Previously, there were no Internal Revenue Service (IRS) limits placed on individuals or cafeteria plans and the employer set the limit for their cafeteria plan. Under the Health Care Act, health FSA, HRA and LFSA plans will be limited to \$2,500 per year. This dollar amount will be indexed for inflation starting after 2013.
- **Third Summary Document Requirement.** In addition to the Plan Document and Summary Plan Description, there will be a third document required to be distributed to all participants 12 months after a plan goes into



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effect. The regulations of this third document are currently being written. To date, the effective date has not been determined.

- **Dependent coverage.** Effective for plan years beginning on or after September 23, 2010 health insurance plans must allow dependent children to be covered up to age 26. Plans should be reviewed and amended timely to reflect these provisions. *Note:* For plans in effect at the time the law was enacted, i.e., “grandfathered plans”, older-aged dependents with eligibility for other employer coverage need not be covered until plan years beginning on or after 1/1/14. The law provides that the benefits provided to these older-aged dependents are tax-favored. Both health plans and cafeteria plans should be reviewed and amended to reflect these provisions.
- **Ban on Discrimination Based on Salary.** Be aware that the rules prohibiting discrimination in favor of highly compensated individuals, currently applicable to self-funded plans, will apply to insured plans beginning on or after 9/23/10; grandfathered plans (plans in existence on 3/23/10) are excluded.
- **Other Group Health Insurance Mandates** that become effective 9/23/10 include:
 - **Ban on preexisting condition exclusions for children.** Group health plans are prohibited from imposing preexisting condition exclusions on enrollees under 19.
 - **Ban on policy rescissions.** Group health plans cannot rescind such plan or coverage once an enrollee is covered under the plan, except in the event of fraud or intentional misrepresentation of material fact.
 - **Ban on annual and lifetime limits.** Group health plans are prohibited from establishing lifetime limits and unreasonable annual limits on the dollar value of “minimum essential benefits” (to be defined by regulations) for a participant or beneficiary.
 - **Prohibiting cost sharing requirements for Preventive Health Services.** Group health plans must provide coverage for certain maternal and preventive health services, as well as evidence-based items or services recommended by the U.S. Preventive Services Task Force, without imposing any cost sharing requirements.
 - **Establishing an Independent Appeals Process.** Be aware that enhanced appeal rights will be made available in group health plans, including certain external review processes similar to what some states currently allow. Plans exempt from ERISA will become subject to the appeal rights currently applicable to ERISA plans.
- **New Form W-2 Reporting Rules.** Beginning with the 2011 tax year, employers are required to disclose the aggregate cost of any employer-sponsored health insurance coverage on the Form W-2 (effective for 2011 W-2’s to be filed in 2012). This will be determined in a manner similar to calculating the COBRA premium, excluding the 2% administrative fee. It does not include salary reduction contributions to an FSA, HSA or MSA. Future guidance will explain the impact, if any, this will have on the current HSA reporting requirement in Box 12 of the W-2.



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- **Medicare surtax on high income individuals.** Beginning January 1, 2013, the Medicare payroll tax rate of 1.45% will increase to 2.35% for wages earned over \$200,000 for single filers and \$250,000 for joint filers. Employers are directed to withhold the increased amount from all workers with wages exceeding \$200,000 and any over withheld or under withheld tax will be reconciled when the employee files their personal income tax return.
- **Notice of any material modification of benefits** must be provided no later than 60 days *prior* to the effective date of the change.
- **Early retiree reinsurance program.** No later than 6/21/10, reinsurance will be made available to employers offering early retiree health benefits to individuals aged 55 and not yet eligible for Medicare. Employers should review their early retiree health benefit programs to determine what portion of the benefit might be available for reimbursement. Be prepared to get early retiree plans certified once the process is developed.
- **Medicare Part D subsidy.** Employers seeking the subsidy for providing prescription drug coverage should review the impact of the changes, and tax consequences of, the benefit.

We will work to ensure that you understand these provisions, and have an optimal strategy in place for managing them. As mentioned earlier, please do not hesitate to call us so that we can assist you in navigating all of the changes this legislation may mean to your business. As further information develops and becomes available, we will continue to keep you informed. Our service team is always ready to assist, please call (800) 815-3023.

Sincerely,

A handwritten signature in black ink, appearing to read "P. Noftsinger", enclosed in a thin black rectangular border.

Philip Noftsinger, CPA
President, CBIZ Payroll